

### **MEDICARE SELECT CHECKLIST**

A Medicare Select program is a Medicare supplement policy or certificate which is permitted to use a restricted network provision, meaning that the payment of benefits can be conditioned, in whole or in part, on the use of network providers.

The policy benefits of a Medicare Select filing should comply with the provisions of the Medicare supplement checklist.

#### **Medicare Select Plan of Operation**

A Medicare Select issuer must file a Plan of Operation which contains at least the following information as required by 806 KAR 17:390, Section 8 (4) and (5):

- ( ) Evidence that services subject to restricted network provisions are available and accessible through network providers.
- ( ) Services can be provided by network providers with reasonable promptness with respect to geographic location and after-hours care.
- ( ) There are sufficient providers to adequately deliver all services subject to restricted network provisions and to make appropriate referrals.
- ( ) There are written agreements with network providers which describe specific responsibilities.
- ( ) Emergency care is available 24 hours a day, 7 days per week (Section 8(4))
- ( ) The written agreements with network providers prohibit balance billing or seeking recourse from a Medicare Select subscriber (other than charges set forth in the policy or certificate).

- ( ) A statement or map clearly describing the service area
- ( ) A description of the grievance procedure
- ( ) A description of the quality assurance program, including:
  - ( ) The formal organizational structure (Section 8 (4)(d)1.)
  - ( ) The written criteria for selection, retention, and removal of network providers
  - ( ) The procedures for evaluating quality of care by network providers and the process to initiate corrective action when warranted
- ( ) A list, by description and specialty, of the network providers
- ( ) Copies of the written information proposed to be used to comply with the disclosure requirements described below
- ( ) Any other information requested by the commissioner

Note: Except for changes to the list of network providers, any proposed changes to the Plan of Operation must be filed prior to implementing the change. Changes will be considered approved after 30 days unless they are specifically disapproved.

An updated list of network providers shall be filed at least quarterly.

### **Specific Medicare Select Policy Provisions**

- ( ) A Medicare Select policy or certificate cannot restrict payment for covered services to network providers if the services are for symptoms requiring emergency care or are immediately required for unforeseen illness, injury, or condition - or if it is not reasonable to obtain such services through a network provider. (806 KAR 17:390, Section 8(7))

- ( ) A Medicare Select policy or certificate shall provide for full payment for covered services that are not available through a network provider. (806 KAR 17:390 Section 8(8))
- ( ) A Medicare Select policy or certificate shall provide for continuation of coverage in the event the Secretary of Health and Human Services discontinues the Medicare Select program, or it is not reauthorized. (806 KAR 17:390 Section 8(14))
- ( ) A Medicare Select policy or certificate should contain a description of the grievance procedure. (806 KAR 17:390 Section 8(11))
- ( ) A Medicare Select issuer must have available a policy or certificate with comparable or lesser benefits that does not contain a restricted provider network. (806 KAR 17:390 Section 8(12))

### **Medicare Select Disclosure Statement**

A Medicare Select issuer shall make full and fair disclosure in the writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. (806 KAR 17:390 Section 8(9)) Although it is not specific in the regulation, Leslie Clune, Office of the General Counsel, Health and Human Services, telephone 202-619-1212, informed us that this is to be in the form of a separate document to be delivered to the applicant prior to the policy issue. The disclosure statement should include:

- ( ) An outline of coverage to comply with the provisions of the basic Medicare Supplement checklist
- ( ) A description (including address, phone number, and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers
- ( ) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized
- ( ) A description of coverage for emergency and urgently needed care and out-of-service area coverage

- ( ) A description of limitations on referrals to restricted network providers and to other providers
- ( ) A description of the policyholder's right to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer
- ( ) A description of the Medicare Select issuer's quality assurance program and grievance procedure
- ( ) The filing should include a form to be signed and dated by the applicant stating that the applicant has received the information required above and understands the restrictions of the Medicare Select policy or certificate. (806 KAR 17:390 Section 8(10))
- ( ) Section 8(4)(a)5. No balance billing or seeking reimbursement from the individual (Provider contract)